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28 Texas Administrative Code

Chapter 134 - BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER B: MISCELLANEOUS REIMBURSEMENT
AMEND: §134.110

SUBCHAPTER F: PHARMACEUTICAL BENEFITS
AMEND: §134.502

SUBCHAPTER G: PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE
AMEND: §134.600

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Subchapter B - MISCELLANEOUS REIMBURSEMENT

§134.110. ***Reimbursement of Injured Employee for Travel Expenses Incurred.***

(a) An injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when:

(1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives and the distance traveled to secure medical treatment is greater than 30 miles one-way; or

(2) the distance traveled to attend a designated doctor examination, required medical examination, or post designated doctor treating or referral doctor examination is greater than 30 miles one-way.

(b) The injured employee shall submit the request for reimbursement to the insurance carrier within one year of the date the injured employee incurred the expenses.

(c) The injured employee's request for reimbursement shall be in the form and manner required by the division and shall include documentation or evidence (such as itemized receipts) of the amount of the expense the injured employee incurred.

(d) The insurance carrier shall reimburse the injured employee based on the travel rate for state employees on the

date travel occurred, using mileage for the shortest reasonable route.

(1) Travel mileage is measured from the actual point of departure to the health care provider's location when the point of departure is:

(A) the employee's home; or

(B) the employee's place of employment.

(2) If the point of departure is not the employee's home or place of employment, then travel mileage shall be measured from the health care provider's location to the nearest of the following locations:

(A) the employee's home;

(B) the place of employment; or

(C) the actual point of departure.

(3) Total reimbursable mileage is based on round trip mileage.

(4) When an injured employee's travel expenses reasonably include food and lodging, the insurance carrier shall reimburse for the actual expenses not to exceed the current rate for state employees on the date the expense is incurred.

(e) The insurance carrier shall pay or deny the injured employee's request for reimbursement submitted in accordance with subsection (c) of this section within 45 days of receipt.

(f) If the insurance carrier does not reimburse the full amount requested, partial payment or denial of payment shall include a plain language explanation of the reason(s) for the reduction or denial. The insurance carrier shall inform the injured employee of the injured employee's right to request a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

This provision will become effective 3/30/2014.

Subchapter F - PHARMACEUTICAL BENEFITS

§134.502. ***Pharmaceutical Services*****.**

(a) A doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter medication (OTC) alternatives as clinically appropriate and applicable in accordance with applicable state law and as provided by this section.

(1) It shall be indicated on the prescription that the prescription is related to a workers' compensation claim.

(2) When prescribing an OTC medication alternative to a prescription drug, the doctor shall indicate on the prescription the appropriate strength of the medication and the approximate quantity of the OTC medication that is reasonably required by the nature of the compensable injury.

(3) The doctor shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify

on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

(4) The doctor shall prescribe OTC medications in lieu of a prescription drug when clinically appropriate.

(b) When prescribing, the doctor shall prescribe in accordance with §134.530 and §134.540 of this title (relating to Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks and Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks, respectively).

(c) The pharmacist shall dispense no more than a 90-day supply of a prescription drug.

(d) Pharmacies and pharmacy processing agents shall submit bills for pharmacy services in accordance with Chapter 133 (relating to General Medical Provisions) and Chapter 134 (relating to Benefits--Guidelines for Medical Services, Charges, and Payments.

(1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.

(2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

(3) A pharmacy may contract with a separate person or entity to process bills and payments for a medical service; however, these entities are subject to the direction of the pharmacy and the pharmacy is responsible for the acts and omissions of the person or entity. Except as allowed by Labor Code §413.042, the injured employee shall not be billed for pharmacy services.

(e) The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination.

(f) The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th day after receipt of request. The prescribing doctor shall not bill for nor shall the insurance carrier reimburse for the statement of medical necessity.

(g) In addition to the requirements of §133.240 of this title (relating to Medical Payments and Denials) regarding explanation of benefits (EOB), at the time an insurance carrier denies payment for medications for any reason related to compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons related to an adverse determination, the insurance carrier shall also send the EOB to the injured employee, and the prescribing doctor.

This provision will become effective 3/30/2014.

Subchapter G - PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

§134.600. NEW Section Name: ***Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care*** ~~***Preauthorization, Concurrent Review, and Voluntary Certification of Health Care***~~**.**

(a) The following words and terms when used in this chapter shall have the following meanings, unless the

context clearly indicates otherwise:

(1) Adverse determination: A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.

(2) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.

(3) Concurrent utilization review: a form of utilization review for on-going health care listed in subsection (q) of this section for an extension of treatment beyond previously approved health care listed in subsection (p) of this section.

(4) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic individuals. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.

(5) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the division from preauthorization and concurrent utilization review requirements except for those provided by subsections (p)(4) and (q)(2) of this section.

(6) Final adjudication: the commissioner has issued a final decision or order that is no longer subject to appeal by either party.

(7) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care.

(8) Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee.

(9) Reasonable opportunity: At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(10) Requestor: the health care provider or designated representative, including office staff or a referral health care provider or health care facility that requests preauthorization, concurrent utilization review, or voluntary certification.

(11) Work conditioning and work hardening: return-to-work rehabilitation programs as defined in this chapter.

(b) When division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the commissioner;

(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

(d) The insurance carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(e) The insurance carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or injured employee to request preauthorization or concurrent utilization review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to within the time limits established in subsection (i) of this section. The insurance carrier shall also comply with any additional requirements of §19.2012 of this title (relating to URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care).

(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

(1) name of the injured employee;

(2) specific health care listed in subsection (p) or (q) of this section;

(3) number of specific health care treatments and the specific period of time requested to complete the treatments;

(4) information to substantiate the medical necessity of the health care requested;

(5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;

(6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;

(7) name, professional license number or national provider identifier of the health care provider who will

render the health care if different than paragraph (6) of this subsection and if known;

(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and

(9) estimated date of proposed health care.

(g) A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the insurance carrier in accordance with Labor Code §408.0042.

(1) The request shall be in the form of a treatment plan for a 60 day timeframe.

(2) The insurance carrier shall review requests submitted in accordance with this subsection for both medical necessity and relatedness.

(3) If denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with subsection (m) of this section.

(4) The requestor or injured employee may file an extent of injury dispute upon receipt of an insurance carrier's response which includes a denial due to an unrelated injury or diagnosis, regardless of whether an adverse determination was also issued.

(5) Requests which include a denial due to an unrelated injury or diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include the dispute of an adverse determination may proceed to medical dispute resolution for the issue of medical necessity in accordance with subsection (o) of this section.

(h) Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury, regardless of:

(1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(2) the insurance carrier's liability for the injury; or

(3) the fact that the injured employee has reached maximum medical improvement.

(i) The insurance carrier shall contact the requestor or injured employee within the following timeframes by telephone, facsimile, or electronic transmission with the decision to approve the request; issue an adverse determination on a request; or deny a request under subsection (g) of this section because of an unrelated injury or diagnoses as follows:

(1) three working days of receipt of a request for preauthorization; or

(2) three working days of receipt of a request for concurrent utilization review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(j) The insurance carrier shall send written notification of the approval of the request, adverse determination on the request, or denial of the request under subsection (g) of this section because of an unrelated injury or diagnosis within one working day of the decision to the:

(1) injured employee;

(2) injured employee's representative; and

(3) requestor, if not previously sent by facsimile or electronic transmission.

(k) The insurance carrier's failure to comply with any timeframe requirements of this section shall result in an administrative violation.

(l) The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include:

(1) the specific health care;

(2) the approved number of health care treatments and specific period of time to complete the treatments;

(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and

(4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review).

(m) In accordance with §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), the insurance carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for the adverse determination prior to issuing the adverse determination. The notice of adverse determination must comply with the requirements of §19.2009 of this title and if preauthorization is denied under Labor Code §408.0042 because the treatment is for an injury or diagnosis unrelated to the compensable injury the notice must include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference).

(n) The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented.

(o) If the initial response is an adverse determination of preauthorization or concurrent utilization review, the requestor or injured employee may request reconsideration orally or in writing. A request for reconsideration under this section constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations).

(1) The requestor or injured employee may within 30 days of receipt of a written adverse determination request the insurance carrier to reconsider the adverse determination and shall document the reconsideration request.

(2) The insurance carrier shall respond to the request for reconsideration of the adverse determination:

(A) as soon as practicable but not later than the 30th day after receiving a request for reconsideration of an adverse determination of preauthorization; or

(B) within three working days of receipt of a request for reconsideration of an adverse determination of concurrent utilization review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(3) In addition to the requirements in this section and §19.2011 of this title, the insurance carrier's

reconsideration procedures shall include a provision that the period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.

(4) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services prior to the issuance of an adverse determination on the request for reconsideration, the insurance carrier shall comply with the requirements of §19.2010 and §19.2011 of this title, including the requirement that the insurance carrier afford the requestor a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

(5) The requestor or injured employee may appeal the denial of a reconsideration request regarding an adverse determination by filing a dispute in accordance with Labor Code §413.031 and related division rules.

(6) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request. The insurance carrier shall review the documentation and determine if any substantial change in the injured employee's medical condition has occurred or if all necessary clinical prerequisites have been met. A frivolous resubmission of a preauthorization request for the same health care constitutes an administrative violation.

(p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(q) The health care requiring concurrent utilization review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all work hardening or work conditioning services requested by:

(A) non-exempted work hardening or work conditioning programs; or

(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in subsection (p)(12) of this section;

(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;

(4) investigational or experimental services or use of devices;

(5) chronic pain management/interdisciplinary pain rehabilitation; and

(6) required treatment plans.

(r) The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent utilization review under subsections (p) and (q) of this section respectively.

(1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity.

(2) The insurance carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective utilization review of medical necessity.

(3) If there is no agreement between the insurance carrier and requestor, health care provided is subject to retrospective utilization review of medical necessity.

(s) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims by the division in accordance with Labor Code §408.0231(b)(4) and other sections of this title.

(t) The insurance carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent utilization review approval or adverse determination decisions, and appeals, including requests for reconsideration and requests for medical dispute resolution, if any. The insurance carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the division, the insurance carrier shall submit such information in the form and manner prescribed by the division.

(u) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title (relating to Agents' Licensing). Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

This provision will become effective 3/30/2014.

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